State of Tennessee

2007 POS member handbook

CIGNA HealthCare of Tennessee

We are where you are.

CIGNA®

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IMPORTANT NOTICE

This member handbook explains many features of the **Point of Service (POS)** health care option. It describes your benefits in general terms and is not intended to give all the details of every benefit, limitation, or exclusion. The Plan Document is the official legal publication that defines benefits. A copy is available for your review from your insurance preparer or from the State of Tennessee Division of Insurance Administrations web site at www.state.tn.us/finance/ins/.

For services to be covered, they must be determined to be medically necessary.

If you are unsure about whether a procedure, type of facility, equipment, or any other expense is covered, ask your physician to submit a pre-determination request form to the claims administrator describing the condition and planned treatment. Pre-determination requests typically take up to three weeks to review.

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Welcome

Welcome to CIGNA HealthCare! CIGNA HealthCare is the claims administrator for the Point of Service (POS) plan statewide, and our business is your health. Your plan provides access to quality care, close to where you live and work. You will also enjoy the freedom to choose your doctor –either in or out of our network –and convenient, no-referral access to specialists. We encourage you to use online tools and resources to help you stay healthy and get the most of your plan. We stand ready to help, so just call the toll-free number on your CIGNA HealthCare ID card if you have questions or concerns. CIGNA HealthCare of Tennessee – We Are Where You Are.

If you live or work in any Tennessee county, you are eligible for the POS option.

Plan Administration and Claims Administration

The Division of Insurance Administration of the Department of Finance and Administration is the plan administrator and CIGNA HealthCare is the claims administrator. This program is administered using the benefit structure established by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund consisting of your premiums and the employer's contributions (if applicable) and not by an insurance company. CIGNA HealthCare is contracted by the state to process claims, establish and maintain adequate provider networks, and conduct utilization management reviews.

Claims paid in error for any reason will be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by contacting the Division of Insurance Administration.

Eligibility and Enrollment Topics

Please refer to your Insurance Handbook, available from your insurance preparer, for all information related to eligibility and enrollment. Eligibility and enrollment are managed by the plan administrator.

Customer Service

Before you enroll, CIGNA HealthCare provides a Pre-Enrollment Information line that is available to help you and your family members learn about your benefits and advantages of CIGNA HealthCare. We invite you to contact us with any questions during your enrollment period.

CIGNA HealthCare Pre-Enrollment Information Line: 1.800.564.7642

For information about specific health care claims, please call customer service. Our representatives are familiar with your specific coverage and are available to answer your questions. When contacting customer service, you will be asked to verify your identity and give information from your identification card.

CIGNA HealthCare Customer Service: 1.800.CIGNA24 (1.800.244.6224)

Web Site

Before you enroll visit www.cigna.com and see what we are about. Please visit http://cigna.benefitnation.net/cignadol/default.asp?employer=3323504 to view participating providers that are specific to the State of Tennessee if you are not yet enrolled in this plan. Once you enroll myCIGNA.com is your personalized, convenient and secure web site. You can review your benefits plan information; find participating physicians, specialists, pharmacies and hospitals closest to home or work; view the status of your claims; order a new CIGNA HealthCare ID card; and more.

You also have access to a number of convenient, helpful tools.

- **Cost Comparison Tools:** Use tools to compare costs and help you decide where to get care. You can get average price ranges for certain ambulatory surgical procedures and radiology services. You can also find estimated costs in your region for common medical services and conditions.
- **Pharmacy Tools:** Check your prescription drug out-of-pocket costs, listed by specific pharmacy (including CIGNA Tel-Drug). Review your prescription drug claims history, including number of claims and total cost, for the past 18 months. Click Drug Compare™ to look at condition-specific drug treatments and compare characteristics of more than 200 common medications.
- **Select Quality Care™ Hospital Comparison Tool:** Compare hospitals according to your unique needs and preferences. You can also print out a personalized report or e-mail it to your doctor. Select Quality Care has been approved as an evidence-based hospital referral tool by the Leapfrog Group (a business roundtable that encourages more stringent safety measures to help reduce preventable medical errors).

MEDICAL BENEFITS AT A GLANCE

	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES		
Individual maximum per plan year	$0	$300
Family maximum per plan year	$0	$750
INPATIENT SERVICES		
Physician services	100% benefit	70% of MAC after deductible
Hospital services (includes semi-private room and board, operating room, intensive care, x-ray, laboratory, drugs, supplies and physician services)	$100 copay per admission	70% per diem after deductible and $300 copay per admission
OUTPATIENT SERVICES		
General or routine office visit	$20 copay	70% of MAC after deductible
Specialist office visit	$25 copay	70% of MAC after deductible
X-ray, lab and diagnostics	100% benefit	70% of MAC after deductible
Allergy injection by doctor	$20 copay general/$25 copay specialist	70% of MAC after deductible
Allergy injection by nurse/nurse practitioner	100% benefit	70% of MAC after deductible
Home health care (125 visits per plan year)	$20 copay	70% of MAC after deductible
Home infusion therapy	$20 copay	70% of MAC after deductible
Surgical services – physician	$20 copay general $25 copay specialist	70% of MAC after deductible
Surgical services – facility	100% benefit	70% of MAC after deductible
Chiropractors	$20 copay	70% of MAC after deductible
PREVENTATIVE HEALTH/WELL CARE		
Well child checkup and immunizations	100% benefit	70%of MAC after deductible
Annual physical exam – Adult	100% benefit	70% of MAC after deductible
Family planning	$20 copay	70% of MAC after deductible
Annual hearing and vision screening (see covered medical expenses)	$20 copay general/$25 copay specialist	70% of MAC after deductible
MATERNITY CARE		
Physician care	$20 copay, first visit to diagnose pregnancy only	70% of MAC after deductible
Hospital care	$100 copay per admission	70% per diem after deductible and $300 copay
Midwives (in a licensed healthcare facility)	$20 copay, first visit to diagnose pregnancy only	70% of MAC after deductible
REHABILITATION AND THERAPY SERVICES		
Inpatient services	$100 copay	70% of MAC after deductible
Outpatient services (subject to plan limits)	$20 copay	70% of MAC after deductible
Skilled nursing facility (100 day limit following approved hospitalization)	$25 copay per day	70% per diem after deductible
EMERGENCY CARE (see page 13 for definition/guidelines)		
Emergency room services	$50 copay	$50 copay; 70% of MAC after deductible

MEDICAL BENEFITS AT A GLANCE

	IN-NETWORK	OUT-OF-NETWORK
URGENT CARE		
Received at a walk-in clinic	$20 copay primary $25 copay specialist	70% of MAC after deductible
Received at a hospital emergency room	$50 copay	70% of MAC after deductible and $50 copay
TRANSPORTATION		
Ambulance services (air and ground)	100% of reasonable charges	100% of reasonable charges
If approved for out-of-state exception	80% of reasonable charges	None
If approved for transplant	100% subject to applicable limit	None
APPLIANCES AND EQUIPMENT		
Durable medical equipment	100% benefit	70% of MAC after deductible
Supplies (ostomy, bandages, dressings, diabetic)	$5 copay (34-day supply)	70% of MAC after deductible
HOSPICE CARE		
Through an approved program	100% of MAC	100% of MAC
PRESCRIPTION DRUGS		
Generic	$5 copay	70% of MAC after deductible
Preferred or Formulary	$20 copay	70% of MAC after deductible
Non-Preferred or Non-Formulary	$40 copay	70% of MAC after deductible
Extended prescriptions available for one copay through the home delivery program and certain participating mail-at-retail pharmacies	Prescription claims filed by the covered person will be reimbursed based on the MAC less the copay	Prescriptions will be reimbursed based on the MAC less the applicable coinsurance after deductible
ROUTINE VISION CARE		
Optometrist*	$10 copay	70% of MAC after deductible
Ophthalmologist**	$25 copay	70% of MAC after deductible
DENTISTS		
Extraction of impacted wisdom teeth, excision of solid based oral tumors, accidental injury, orthodontic treatment for correction of facial hemiatrophy or congenital birth defect (subject to plan limits)	100% of reasonable charge after $25 copay	100% of reasonable charge after $25 copay

**For in-network benefits, exams must be obtained from a participating Vision Service Plan (VSP) provider which can be located by calling VSP at 800.877.7195 or online at www.vsp.com. This is only for routine eye care. Limited to one visit/year.*

***Non-routine care such as medical conditions and injuries to the eye are covered under your medical plan. A participating ophthalmologist for these types of care can be located by contacting customer service.*

MAC=Maximum Allowable Charge

Copays represent cost to participant, percentages represent portion paid by the plan.

Covered persons will be responsible for payment of charges above the MAC if non-POS providers are used.

If preauthorization is required but not obtained, benefits will be reduced to 50% of MAC for out-of-network providers.

No benefits will be paid for network providers.

- **HealthQuotient™ Health Risk Assessment:** Take an online questionnaire that can help you identify and monitor your health status. You also can find out how your family health history may affect you, learn about preventive care and check your progress toward healthy goals. And if your results show that you may benefit from other services, you can learn about related CIGNA HealthCare programs on the same site.
- **Healthwise®:** This tool gives you online access to medical content on a wide range of topics, including specific illnesses, first aid and medical exams.
- **Condition Centers®:** Learn more about the prevention and treatment of more than 35 conditions, with links to related CIGNA HealthCare programs when available.
- **Health Record:** Store your personal health information in a central, secure location, including current conditions, medications, allergies, surgeries, immunizations and personal contact information for emergencies.
- **Health Trackers:** Use easy-to-read charts to keep track of your key health measurements such as blood pressure, blood sugar, cholesterol, height and weight.

Mental Health and Substance Abuse

Mental health and substance abuse benefits are administered separately from your medical benefits. Please contact Magellan Health Services at 1-800-308-4934 for assistance in this area. See your agency insurance preparer for detailed benefit information.

Covered Medical Expenses

1. Office visits to a physician or a specialist due to an injury or illness.

2. Family planning and infertility services including history, physical examination, laboratory tests, advice, and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing, and treatment for organic impotence. If fertility services are initiated (including, but not limited to, artificial insemination and in-vitro fertilization), benefits will cease.

3. Nutritional guidance when medically appropriate as determined by the claims administrator.

4. Adult preventive care including one routine physical exam per plan year (age 18+), bone density scans (female age 50+ once per year or 65+ as medically necessary), routine women's health exam including breast exam, Pap smear for cervical cancer screening and pelvic exam (age 18+), cholesterol screening (age 40+) every five years or more often if medically necessary, and immunizations (tetanus, measles, mumps, rubella, pneumococcal, influenza, hepatitis B).

5. Well child visits to physicians including checkups and immunizations, 12 visits combined through age 5. Annual checkups for ages 6-17 and immunizations as recommended by the Centers for Disease Control and Prevention (CDC).

6. Mammogram screenings within the following guidelines: Once as a baseline mammogram between ages 35-39; once every year for ages 40 and over; or when prescribed by a physician and determined to be medically necessary.

7. Prostate screening annually for men who have been treated for prostate cancer with radiation, surgery, or chemotherapy and for men over the age of 45 who have enlarged prostates as determined by rectal examination. This annual testing is also covered for men of any age with prostate nodules or other irregularity noted upon rectal exam. The PSA test will be covered as the primary screening tool of men over age 50 and transrectal ultrasound will be covered in these individuals found to have elevated PSA levels.

8. Hospital room and board and general nursing care in a semi-private room or in a specialty care unit if pre-authorized.

9. Charges for medically necessary surgical procedures and administration of anesthesia.

10. Charges for diagnostic laboratory and x-ray services.

11. An approved hospice program that is designed to provide the terminally ill patient with more dignified, comfortable, and less costly care during the six months before death.

12. Durable medical equipment (DME), consistent with a patient's diagnosis, recognized as therapeutically effective and prescribed by a physician and not meant to serve as a comfort or convenience item. Benefits are provided for either rental or purchase of equipment.

13. Removal of impacted wisdom teeth, excision of solid-based oral tumors, and treatment of accidental injury (other than by eating or chewing) to sound natural teeth.

14. Continuous passive motion machine for knee replacement surgery or anterior cruciate ligament repair for 28 days after surgery.

15. The initial purchase of an artificial limb (prosthetic device) necessary due to an illness or injury and subsequent purchases due to physical growth for a covered dependent through age 18. One additional limb prosthesis past age 18 will be covered if additional surgery has altered the size or shape of the stump, or if a severe medical condition could result from improper fitting of the initial prosthesis. Replacement prosthetic due to normal wear and tear or physical development, with written approval.

16. Smoking cessation aids requiring a prescription with a limit of one 90-day period per year and two 90-day periods per lifetime.

17. Expenses for temporomandibular joint malfunctions (TMJ) including history, exams, and office visits; x-rays of the joint, diagnostic study casts; appliances (removable or fixed); physical medicine procedures such as surgery; and medications.

18. Medically necessary services performed by a registered/licensed physical, occupational, or speech therapist limited to a maximum of 45 visits per condition, per plan year.

19. The first contact lenses or glasses (excluding tinting and scratch resistant coating) purchased after cataract surgery.

20. Multiple pairs of rigid contact lenses that are determined to be medially necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus. Intrastromal Corneal Ring Segments (ICRS) for vision correction are also covered with a diagnosis of keratoconus when certain medical appropriateness criteria are met.

21. Cosmetic surgery only when in connection with treatment of a congenital anomaly that severely impairs the function of a bodily organ or due to a traumatic injury or illness; or reconstructive breast surgery if needed following a covered mastectomy (but not a lumpectomy), as well as surgery to the non-diseased breast to establish symmetry.

22. Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to $500 per calendar year. Coverage for additional training and education is available when determined to be medically necessary by the claims administrator.

23. Insulin, the related syringes (including needle-free syringes when medically necessary as determined by the claims administrator based on the patient's age, weight, skin, and medical condition, and/or the frequency of injections), home blood glucose monitors, and related supplies for the treatment of diabetes as approved by a physician.

24. Screenings of the eyes (not including refractive services and supplies) and hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss when medically necessary. Availability of benefits limited to once per plan year.

25. Certain organ and bone marrow transplant medical expenses and services (preauthorization required). Hotel and meal expenses will be paid at $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.

26. Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, surgical collars, lumbosacral supports, corsets-back and special surgical, trusses, and rigid back or leg braces.

27. Foot orthotics, including therapeutic shoes, if an integral part of a leg brace, depth or custom-molded, including inserts for those with diabetes mellitus and certain related complications, rehabilitative when part of post-surgical or post-traumatic casting care, prosthetic shoes that are an integral part of the prosthesis, and ankle orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses. Such items will be covered when prescribed by a physician if medically necessary as determined by the claims administrator.

28. Home health care when certified and approved as medically necessary by the claims administrator. When ordered by a physician, covered services are limited to intermittent skilled nursing care given or supervised by a registered nurse including up to 30 home health aide visits.

29. Medically necessary ground and air ambulance services to and from the nearest general hospital or specialty hospital.

30. Blood plasma or whole blood (including components and derivatives) unless donated or replaced by you or a family member.

31. Ketogenic diet counseling when approved through case management.

32. Medically appropriate sleep studies and evaluations.

33. Charges, including procedure charges, physician charges, and facility charges, for certain PET scans when determined to be medically necessary and approved by the claims administrator. (Members or physicians should verify medical necessity and benefit eligibility before incurring charges for use of the PET scan technology.)

34. Some surgical weight reduction programs.

35. Colorectal screenings. Beginning at age 50, men and women have one of the following five screening options available: (1) yearly fecal occult blood test (FOBT), (2) flexible sigmoidoscopy every five years, (3) yearly fecal occult blood test and flexible sigmoidoscopy every five years (preferred over either test alone), (4) double contrast barium enema every five years, or (5) colonoscopy every five years. For individuals determined by their physician to be at high risk for colorectal cancer due to medical or family history, screening may need to begin at an earlier age and occur more frequently.

36. Tubal ligation and vasectomy.

37. Routine patient costs related to clinical trials as defined by TCA 56-7-2365.

Excluded Services and Procedures

1. Services provided by a participant's immediate family member, whether by blood, marriage, or adoption.

2. Services not ordered or furnished by an eligible provider.

3. Charges in excess of the maximum allowable charge when using out-of-network providers.

4. Experimental or investigational treatments, procedures, facilities, equipment, drugs, or supplies as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency. (Members are held harmless for charges or services from network providers unless they have signed a waiver accepting responsibility for the cost.)

5. Charges that would be considered a covered injury paid under workers' compensation, regardless of the presence or absence of workers' compensation coverage.

6. Comfort or convenience items.

7. Humidifiers, dehumidifiers, exercise devices, blood pressure kits, heating pads, sun or heat lamps.

8. Podiatric items such as inner soles, corn plasters, foot padding, arch supports, routine foot care, or orthopedic shoes for correction of a deformity or abnormality of the musculoskeletal system unless one or both are attached to a brace. Charges for removal of corns or calluses, or trimming of toenails, with the exception of a diagnosis of diabetes.

9. Hearing aids, including examinations and fittings.

10. Midwife services outside a licensed health care facility.

11. Nonsurgical service for weight control or reduction, including prescription medication.

12. Artificial or nonhuman organ transplants and related services, except for Ventricular Assist Devices (VAD) and Total Artificial Hearts (TAH) when determined to be medically necessary by the claims administrator.

13. Radial keratotomy, LASIK, or other procedures to correct refractive errors; eyeglasses, sunglasses, or contacts including examinations and fitting charges.

14. Surgery or treatment for, or related to, psychogenic sexual dysfunction or transformation.

15. Services or supplies in connection with artificial insemination, in-vitro fertilization, or any procedure intended to create a pregnancy.

16. Wigs.

17. Ear or body piercing.

18. Custodial care, unapproved sitters, day and evening care centers (primarily for rest or for the elderly), or diapers.

19. Programs considered primarily educational and materials such as books or tapes.

20. Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, or collection and handling fees. Charges for telephone consultations.

21. Over-the-counter medications and supplies (except injectable B-12 for pernicious anemia).

22. Hotel charges unless preapproved through the organ transplant program.

23. Cosmetic surgery and related expenses including, but not limited to, scar revision, rhinoplasty, and saline injection of varicose veins.

24. Any dental care, treatment, or oral surgery relating to the teeth and gums including, but not limited to, dental appliances, dental prostheses (such as crowns, bridges, or dentures), implants, orthodontic care, fillings, extractions, endodontic care, treatment of caries, gingivitis, or periodontal disease.

25. Treatment and therapies for maintenance purposes.

26. Reversal of sterilization procedures.

27. Charges for prescriptions that are lost, stolen, misplaced, or forgotten.

28. Charges incurred outside the United States unless traveling for business or pleasure.

29. Charges for bathroom chairs, stools, and tub handrails.

30. Fitness clubs and programs.

How the Plan Works

Choice of Doctors

Under the Point of Service plan, you can choose to seek care from doctors who can provide general or routine care. These doctors include family practice, general practice, internal medicine, OB/GYN, and pediatric physicians. Most individuals establish a doctor patient relationship with these types of physicians.

Members sometime have a need to see a specialist for a medical condition. Simply chose a specialist that participates in the network and schedule an appointment. If a specialist determines that you should be admitted to the hospital or need services that require prior authorization, they will handle these plan requirements for you. However, it is a good idea to contact us to confirm benefits for hospital admissions or other services that require prior authorization.

The Point of Service plan does not require you to choose a primary care physician or PCP. The plan provides benefits for specialist services and you do not need a referral from a primary care physician. To receive maximum benefits, always choose in-network providers and facilities.

OB/GYN Services

Once during each calendar year, you can receive a routine OB/GYN well-woman exam. If your doctor determines you should see another specialist or be admitted to the hospital, all prior authorization requirements will be handled by that physician.

Durable Medical Equipment, Respiratory Equipment and Enteral Nutrition

Apria is the exclusive national provider for durable medical equipment (DME), respiratory equipment and enteral nutrition. Apria has over 500 locations nationwide, however, if needed, Apria and CIGNA HealthCare will work with existing providers on a case-by-case basis to ensure access to members. To help our members and providers receive the highest level of care and service the following process should be followed.

For all DME, respiratory equipment and enteral nutrition, providers should call Apria at 1.800.901.3566 or fax the request to 1.800.723.4288. Prior authorization will still be required for some services and Apria will coordinate that with CIGNA HealthCare. Please be advised that all new orders will require a prescription from the provider for the order to be filled for delivery. Apria is set up on a home delivery model and in most cases the order will be taken and delivered directly to the members' home. In some rare cases or at the member's request, the member may want to physically go to an Apria location. This is typically done if the member would prefer to go at their convenience versus having to schedule a time for an appointment or delivery for an item or service. Turn around time of an order is based on medical necessity and the provider's request. Typical turn around is the day after the order is placed unless it is indicated and requested for same day delivery due to medical necessity. Some custom items or orders will take longer but the turn around will be communicated to the provider and member at the time of order.

CareCentrix (Gentiva) will continue to provide service and care for certain specialty items such as insulin pumps, wound vac, bone growth stints, CPMs and related supplies as well as all traditional home health and infusion-related services. The provider will call 1.800.411.2305 to place an order for these types of services or supplies.

Benefits: In-Network or Out-of-Network

In-network benefits are those provided by a network provider. In most cases, your only expense is a reasonable copayment due when you receive care. With out-of-network benefits, you can receive care from doctors and hospitals not participating in the network and benefits will be provided, but at a reduced level.

If you utilize an out-of-network provider the cost to you will be substantial. You will receive the lower level of benefits and will be required to pay the difference between the maximum allowable charge (MAC) and the actual charge. Also remember certain services will not be covered out-of-network. Your health care coverage does not allow payment for services you receive in-network or out-of-network which are not medically necessary for your condition. If care given is not found to be appropriate and necessary, then no benefits will be available and you will be liable for the services.

Maximum Allowable Charge Defined

In the simplest terms, the maximum allowable charge (MAC) is the maximum amount that we will pay to a particular provider for a particular service. Providers who have contracted with us to provide network services have agreed to accept that amount as payment in full, writing off the rest of the charge after any applicable deductible or copayment is paid by the member. Following is an example of how in-network benefits compare to out-of-network benefits.

Outpatient surgery fee	$5,000.00
MAC	$828.00
IN-NETWORK	
In-network member copayment	$0.00
Plan pays 100% of MAC	$828.00
Patient liability	$0.00
OUT-OF-NETWORK	
Plan pays 70% of MAC after deductible	$369.60
Patient coinsurance (30%)	$158.40
Patient deductible	$300.00
Patient owes MAC difference	$4,172.00
Total patient liability	$4,630.40

CIGNA HealthCare Healthy Babies®

The CIGNA HealthCare Healthy Babies program gives mothers-to-be the information and support they need to make the best choices for mom and baby.

When you enroll in Healthy Babies you'll get valuable educational materials, including:

- Guidelines for a healthy pregnancy and baby.
- Information on health issues that can impact pregnant women and their babies, including stress, depression and gum disease.
- A guide to pregnancy-related topics available through the CIGNA HealthCare 24-Hour Health Information Line.℠
- A list of informative online and telephone resources.
- Information on prenatal care from the March of Dimes®—a recognized source of information on pregnancy and babies.

In addition, you'll have round-the-clock access to a toll-free information line staffed by experienced registered nurses. You may also be eligible for support from a registered nurse case manager if you or your baby has special health care needs.

To enroll, just call the toll-free number on your CIGNA HealthCare ID card, any time during your pregnancy.

Please note: The Healthy Babies program is offered in addition to the services covered as part of a CIGNA HealthCare medical benefit plan. Covered services depend on the CIGNA HealthCare plan offered by your employer.

Urgent Care

Members sometimes have a need for medical care during evenings or on weekends. "Urgent care" is care that is important, but does not result from a life-threatening condition. Urgent care health problems are usually marked by rapid onset of persistent or unusual discomfort associated with an illness. If you need urgent care, contact your doctor or specialist. Many physicians' offices use an answering service after hours. When you call after regular hours, be prepared to describe your symptoms and leave a number where the doctor can call you back. Your doctor will offer advice and the best course of treatment for you.

Examples of urgent care situations are:

- Difficulty in breathing
- Prolonged nose bleed
- Short-term high fever
- Cuts requiring stitches

Emergency Care

If you have a medical emergency, seek treatment at the nearest medical facility. Contact your doctor or our customer service section within

24 hours if you are in the State of Tennessee or 48 hours if you are out-of-state. Your doctor will make arrangements for your follow-up care.

Use of the Emergency Room

The emergency room (ER) should be used only in the case of an emergency or in an urgent care situation when your doctor advises. The highest level of benefits, in-network benefits, is available for any emergency room visit that meets the following definition of an emergency. If out-of-network providers are utilized, benefits will be paid based on reasonable charges.

An "emergency" is a medical condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy (or, with respect to pregnant women, the health of the woman or her unborn child)
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part

The prudent layperson approach is designed to address the issue of the need for a member to seek prompt access to care when symptoms appear serious.

For each covered emergency room visit, you will pay the emergency room copayment unless admitted or if the visit is a follow-up visit for the same episode of care within 48 hours of the initial visit to the emergency room. Should the ER require you to pay in full (not in-network), file the billing statement with our office and you will be reimbursed subject to the terms and conditions of the plan.

CIGNA HealthCare 24-Hour Health Information Line℠

Many members are unsure if their symptoms necessitate the need for Urgent Care or Emergency Care. CIGNA HealthCare's 24-Hour Health Information Line℠ is available 24 hours a day to assist you. Simply call member services, select the prompt for the 24-Hour Health Information Line and opt to speak to a nurse. The nurse will ask you a few questions about your symptoms and situation and direct you to the type of care that should make you more comfortable. If Urgent Care is necessary, the nurse will direct you to the nearest CIGNA Health Care participating provider and assist you with any necessary authorization. If it appears that you need emergency care, the nurse will direct you to call 911 or other emergency services in your area. The nurse will help you access the appropriate services. Any time you are directed to seek immediate medical attention, we'll provide your primary care physician with the details.

Hospitalization

If you need to be hospitalized, your doctor will make the necessary arrangements at a network facility. If you are admitted to a hospital (in-network or out-of-network) without our prior authorization, your benefits will be greatly reduced.

If you are out of the network service area or for some reason are unable to reach your doctor before seeking care, you should notify your doctor of any urgent care hospitalization within 24 hours (48 hours if you are out-of-state) of your admission. You should also notify your physician of emergency admissions within the same timeframe. This allows your doctor to make necessary arrangements for any follow-up care. If you have seen a specialist and need to be admitted to a hospital, your specialist will coordinate your hospital care with our office. Maternity admissions do not require preauthorization.

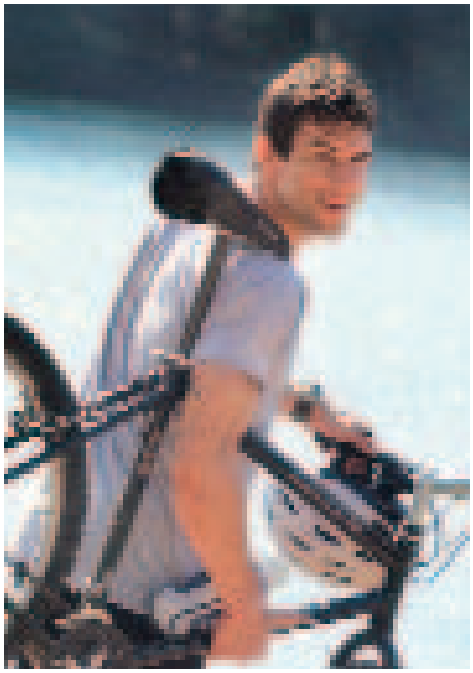
If you are readmitted within 48 hours of the initial visit for the same episode of an illness or injury, the required copayment will be waived.

Guest Privileges Program

The CIGNA HealthCare Guest Privileges Program provides health care coverage when you are away from home for an extended period. Whether your job takes you to a new city for a few months, or one of your participating family members is away at school.

When away for a temporary period of more than 60 days, but no more than two years, you or your participating family member can inquire with a CIGNA HealthCare customer service representative to see if you are eligible for the program. If CIGNA HealthCare has a POS network in the area you are temporarily located and your medical plan design meets that specific state' legislation and mandates then you will be eligible to participate. You will not just be covered for emergency care, but for all of your routine and preventive care benefits as well.

To inquire about guest privileges, contact customer service and a representative will discuss your situation and confirm your eligibility for the program. If you are eligible, the representative will take



your information and enroll you in the program. Further information will then be mailed to your home address.

When you're ready to come home, call CIGNA HealthCare's customer service number at least one week before you leave your temporary residence. A customer service representative will make sure your coverage will be changed back to your original home location as it was before you left.

PLEASE REMEMBER
To ensure smooth transition of coverage to your guest location or back to your home area when you return, be sure to call customer service at least one week before your move. Failure to call may result in benefits being denied.

The benefit plan available at your guest location will be the same as your home benefit plan. However, in some situations, state mandates may mean a difference in benefits. Call customer service for assistance with any benefits questions.

Children living away from home may participate in the program as long as they continue to meet dependent and/or student eligibility status requirements.

Prior Authorization

Prior authorization is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with medical needs of the member and with patterns of care of an established managed care environment for treatment of a particular illness, injury, or medical condition. Prior authorization is required for certain services including, but not limited to:

- Inpatient hospital services
- Skilled nursing facility stays
- Home health care
- Inpatient rehabilitation services
- Obesity surgery
- Major skin procedures
- Face/jaw surgery (except trauma)
- Transplants
- Breast reduction
- Hysterectomy (except cancer surgery)
- Back/spine (except trauma, malignancy)

Certain drugs used for home infusion therapy also require prior authorization. All providers for the above services should request these authorizations prior to services being rendered, except in an emergency situation. When a prior authorization is required, but not obtained, benefits will be reduced to 50 percent of medically necessary expenses for out-of-network providers and no benefits will be paid for network providers.

Coordination of Benefits with Other Insurance Plans

If you are covered under two different insurance plans, benefits will be coordinated for reimbursement up to 100 percent of allowable charges. At no time should reimbursement be more than 100 percent of actual expenses. If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included in the Plan Document. Different coordination of benefit rules apply based on the type(s) of policies you may have and the status of those policies (e.g., active, retired, COBRA). If your spouse has coverage through his or her employer, and has you covered, then that coverage would be primary for your spouse and secondary for you. When this medical plan is primary, the benefits of this plan are calculated just as if the other plan did not provide benefits. Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. The determination of primary or secondary coverage may be altered in the case of divorced parents when a court decree specifically designates the parent whose coverage will be primary. A copy of the court decree should be submitted to our office.

Once a year you will be asked to validate the information on file concerning other coverage. This is done because it is not uncommon for this type of information to change. Periodic validation helps us ensure accurate claims payments. The completed form letter must be received before any further claims processing can take place.

Pharmacy Coordination of Benefits with Other Insurance Plans

In order to ensure timely reimbursement of pharmacy costs when coordinating with another insurance company or when paid out-of-pocket while traveling, please follow the following instructions:

1. Retrieve the claim form on www.mycigna.com.

2. Complete ALL information in the top sections.

3. Sign and date the certification statement in the area provided.

4. Complete the return address section of the form.

5. Submit a separate form for each family member.

6. The lower section must be completed in full for each prescription dispensed. If you have questions regarding the information needed to complete the form, contact your pharmacist.

7. For more than four prescriptions, use additional forms as necessary.

8. Mail the claim form within 13 months of the prescription fill date, along with the original receipts (not cash receipts), to Connecticut General Life Insurance Company, Pharmacy Service Center, P.O. Box 3598, Scranton, Pennsylvania 18505-0598.

Claims Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) a lawsuit settlement from payments made by a third-party insurance company. This would include automobile or homeowners insurance, whether yours or another's. You are required to assist in this process and should not settle any claim without written consent from our subrogation department.

Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses incurred for medically necessary services are covered at the in-network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Claims from a non-English speaking country should be translated to standard English at the covered person's expense. Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

Benefit Level Exceptions

Two types of exceptions — unique care and continuous care — may be granted for which benefits will be paid at the in-network level to an out-of-network provider or facility. All requests for exceptions are reviewed individually by our office. Exceptions will be granted only for medical necessity, not for convenience. To apply for a unique or continuous care exception, work with your provider to submit the following information in a letter to our office address, attention State of Tennessee Unique Care Coordinator. Within two to three weeks, you will be notified whether your request is granted or denied. If the items listed below are not provided with the initial request, the decision may be delayed until all pertinent information can be gathered.

- Patient name and ID number
- Name and type of provider you are requesting
- Diagnosis and treatment plan, date(s) of service
- A statement explaining why this treatment cannot be received at a network facility or provided by a network physician

Unique Care Exceptions

A unique care exception can be granted for treatment not routinely available from a network provider in an employee's geographic area. This exception is based on the patient's condition or need for a particular physician and must be requested before receiving care. We will determine whether a network provider is available to provide treatment for the illness or injury.

If a unique care exception is granted, benefits are paid at the in-network level. Any charges above the maximum allowable are the patient's responsibility. If distance (out-of-state) traveling is required, reimbursement will be at 80 percent of commercial coach airfare or ground travel at the state approved mileage rate, if appropriate. When unique care exceptions are granted, a time frame for this approval is given. If the need for unique care is anticipated beyond the stated time frame, then another unique care request must be submitted before the time frame is exceeded. Updated medical information documenting the continued need for out-of-network care will be required. The review of this request to extend a unique care approval will include an examination of the available network in an effort to determine if the required care can now be accessed within the network.

Continuous Care Exceptions

A continuous care exception can be granted when a patient is undergoing an active treatment plan for a serious medical condition, including pregnancy. This exception takes into account a patient's established relationship with an out-of-network provider. Our medical director will determine the time frame in which continuous care can be covered. Any charges above the maximum allowable are the patient's responsibility.

Coverage For Second Surgical Opinion Charges

In some instances, you have the option to receive a second surgical opinion. Second surgical opinions are not required. The second surgical opinion must be obtained from a surgeon qualified to perform the surgical procedure, but who is not in the same medical group as the physician who originally recommended surgery.

Charges for the second surgical opinion and any tests performed in obtaining the second surgical opinion will be paid at 100 percent of the maximum allowable charge (no copayment required) if a network provider is used.

If you wish to obtain a second surgical opinion about a procedure not included on the list below, normal plan benefits and rules apply. Any surgeries (including those listed) must be medically necessary to be approved.

- Bone and joint surgery of the foot
- Cataract extraction with and without implant
- Cholecystectomy
- Hysterectomy
- Knee surgery
- Septoplasty/sub-mucous resection
- Prostatectomy
- Spinal and disc surgery
- Tonsillectomy and adenoidectomy
- Mastectomy
- Elective C-section

Case Management

Case management is a program that promotes quality and cost effective coordination of care for members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries. Members who need case management are identified and contacted by phone or in writing to discuss or propose alternative treatment plans. Members may also contact customer service if they believe they would benefit from case management. In situations involving medical appropriateness, a case manager may approve additional speech, occupational, and physical therapy visits beyond plan limits.

Filing Claims

Our office is responsible for all medical plan claims processing. When you visit a network doctor or facility, be sure and show your identification card. The provider will file your claim directly. These network providers must file your claim within six months of the date of service. All questions regarding claims, including requests for claim forms, should be addressed to customer service.

If you visit an out-of-network doctor or facility, you may be responsible for filing claims. Out-of-network providers may also require payment in full at the time of service. The appropriate form must be used and a separate claim form must be completed for each individual who has received services. More than one bill can be submitted on a claim form. For out-of-network providers, you have 13 months from the date of service to file claims and be eligible for reimbursement.

Healthy Rewards Program®

CIGNA Healthy Rewards provides access to a range of health and wellness programs and services not covered by many traditional plans including, but not limited to, Weight Watchers®, Jenny Craig, tobacco cessation programs, acupuncture, fitness club memberships, laser vision care, massage therapy, health & wellness products and discounts on popular magazines. This program can save you money by providing discounts on these services when you use Healthy Rewards participating providers. There are no referrals, no claim forms, and no catch! To locate participating providers, call 1.800.870.3470 or visit myCIGNA.com.

Pharmacy Program

Three levels of benefits are available for prescription drugs, and your choice determines the copayment amount you pay each time you have your drugs dispensed by a participating network pharmacy.

- Generic drugs are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective, and affordable alternatives to brand name drugs, and are available in many instances.
- Preferred brands are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the preferred drug list. This list includes many popular brand-name drugs.
- Non-preferred brands are in the third tier and will cost you the highest copayment.

Limitations

Prescriptions may be filled for the quantity specified by your physician for a single course of treatment up to a 34-day supply at retail or, if appropriate, up to a 102-day supply through the home delivery program and certain participating mail-at-retail pharmacies.

Certain drugs may have prior authorization requirements or specific quantity limits. These drugs cannot be dispensed by the pharmacist in an amount greater than the specified limit or where prior authorization has not been obtained by your physician. You should talk to your doctor if you encounter problems with the quantity limits or prior authorization requirements of the pharmacy program.

Exclusions

Some types of medications are not covered by your plan. An exclusion does not mean you cannot have a particular drug; it simply means that no benefits will be provided and you will be responsible for the total cost of the drug.

Filling a Prescription at a Retail Pharmacy

Visit a participating network pharmacy and show your ID card when you purchase your prescription. Pay the appropriate copayment for the prescription at that time and your network pharmacist will electronically file your claim. If filling an extended-duration prescription at retail, be sure to use a participating mail-at-retail provider.

If you use a non-network pharmacy, you must pay all costs and file the claim with the claims administrator. Contact customer service for the appropriate form. After you meet the annual out-of-network deductible, you will be responsible for paying 30 percent of the maximum allowable charge as well as any amount above the maximum allowable charge on each receipt submitted. This will result in a greater cost to you. Your cost will also be greater if you utilize a network pharmacy and fail to have the claim filed electronically. All requirements such as quantity limits and prior authorization apply.

If you are planning a trip and need to purchase medications ahead of time, call member services to request an early refill override. If you are out of your service area and need to obtain a prescription, you may be required to pay in full at the time of purchase and submit your claim for reimbursement. Please visit our website for a pharmacy claim form should this situation occur.

Filling a Prescription Using the Home Delivery Program

Your CIGNA HealthCare plan includes the CIGNA Tel-Drug home delivery pharmacy program, an easy way to fill prescriptions for covered medications and have them delivered to your door. It is ideal for maintenance medications and can be used for new prescriptions and refills.

To get started, visit www.teldrug.com or call 1.800.TEL.DRUG (1.800.835.3784). Our Interactive Voice Response system, available 24 hours a day, can assist you with refills, provide status of recent orders, answer general pharmacy questions, and request assistance from pharmacist for urgent situations. Our Customer Service Representatives are available Monday-Friday, 7 a.m.-10 p.m. CST and Saturday, 8a.m.-5 p.m. CST to assist with any other requests.

To switch to the convenience of CIGNA Tel-Drug for your next refill, try our QuickSwitch® program. Call us at 1.800.285.4812, option 1, extension 501. We'll handle the change for you – there's NO paperwork! Your medication will arrive at your door, and there is no charge for deliveries.

Specialty Pharmacy Program

The Specialty Pharmacy Program is a cost-effective and convenient way to purchase injectable medications that are covered under pharmacy or medical benefit plans. (Insulin and insulin supplies are not part of this program but are covered under your CIGNA HealthCare pharmacy benefit). There are no claim forms. CIGNA Tel-Drug will directly bill your benefits plan for your medication.

Member Rights and Responsibilities

Member Rights

You have the right to:

- Be treated with respect and dignity.
- Expect that any information you give will be treated in a confidential manner.
- Information about policies and services of the plan.
- Information regarding network providers.
- Medically necessary and appropriate medical care.
- Information about your health.
- Make decisions about your health care with practitioners.
- Voice complaints about your health care providers, the care given to you, or the Point of Service plan. You can expect an answer within a reasonable time. You also have the right to formally appeal this answer if you do not agree.
- A candid discussion of appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage.

Confidentiality and Privacy

At CIGNA HealthCare, we are committed to maintaining the confidentiality of our members' health information. We have established policies and safeguards to protect oral, written and electronic information across our organization.

INFORMATION ABOUT CIGNA HEALTHCARE PRIVACY PRACTICES

Our Notice of Privacy Practices is distributed at enrollment to all members covered under a medical insurance policy. Customers covered under self-insured medical plans will receive notices from their employers and can obtain a copy of CIGNA HealthCare's notice by calling Member Services.

RELEASE OF CONFIDENTIAL INFORMATION

We will not use or disclose your confidential information for any purpose other than the purposes permitted by the HIPAA Privacy Rule without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment unless you authorize it.

ACCESS TO YOUR MEDICAL RECORDS

You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain. We may charge you copying and mailing costs. Under limited circumstances, we may deny you access to a portion of your records. Instructions on how to obtain a copy of your records will be included in the privacy notice you receive from CIGNA HealthCare or your employer after you enroll.

INFORMATION TO THIRD PARTIES

We may disclose your confidential information to the plan administrator or their designated representatives so they can monitor, audit, and otherwise administer the health benefit plan in which you participate.

Members can take comfort in knowing that confidentiality is important. You are encouraged to call one of the member service representatives if you have questions about privacy policies and practices.

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complications during any stage of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same annual deductibles and coinsurances as other services and preexisting waiting periods apply, if applicable.

Member Responsibilities

Members are responsible for:

- Reading the member materials in their entirety and complying with the rules and limitations as stated.
- Contacting in-network providers to arrange for medical appointments as necessary.

- Notifying in-network providers in a timely manner of any cancellations of appointments.
- Paying the coinsurance and deductibles as stated in the benefit plan documents at the time service is provided.
- Receiving a pre-authorized referral for services, when required, and complying with the limits of the pre-authorized referral.
- Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.
- Using in-network providers consistent with the applicable benefit plan.
- Providing, to the extent possible, information needed by professional staff in order to care for the member.
- Following instructions and guidelines given by those providing health care services.

Appeal Procedures

If you experience a problem relating to the plan policies or the services provided, there are established procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

Administrative Appeal

To file an appeal regarding an administrative process or decision (e.g., transferring between health plans, effective dates of coverage issues, or timely filing issues) contact your agency or workplace insurance preparer immediately.

Mental Health and Substance Abuse Appeals

Contact Magellan Health Services at 1-800-308-4934 for EAP, mental health and substance abuse appeals.

Appealing to the Claims Administrator

If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call customer service to discuss the issue. If the issue cannot be resolved through customer service, you may file a formal request for review or member grievance by completing the appropriate form and returning it within the specified time frame. When your completed form is received, you will get an acknowledgement letter advising you what to expect regarding the processing of your grievance. When a determination is made, you will be notified in writing and advised of any further appeal options.

If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services (e.g., because the member cannot afford to pay for such services), then providers may request an expedited reconsideration. If the treating provider or primary care physician fails to request the reconsideration and decides not to provide urgently needed services, then the member, or someone acting on the member's behalf, may request the expedited reconsideration. If we agree that it is appropriate to conduct an expedited reconsideration, we will inform the member of our decision as quickly as possible based on the circumstances of the care, including the ability to obtain information concerning the case from the provider.

Please Note: The expedited reconsideration process is only applicable in situations where a benefit determination or a preauthorization denial has been made prior to services being received.

Appealing to the Plan Administrator

The State of Tennessee, Division of Insurance Administration has an appeal process that is available to you AFTER you have exhausted the grievance process with the claims administrator. Appeals must be requested in writing within two years of the claim determination or decision. To file an appeal at the state level, the member should send a letter and supporting documentation (e.g., explanation of benefit statements, decision letters, statements from healthcare providers, and medical records) to:

Appeals Coordinator, Division of
Insurance Administration
13th Floor, Wm. R. Snodgrass
Tennessee Tower
312 Eighth Avenue North
Nashville, TN 37243

It is a good idea to maintain a copy of all correspondence you send. Specific questions regarding the appeal process may be directed to the appeals coordinator at 615-741-3590 or 1-800-253-9981.

The appeals coordinator in the Division of Insurance Administration will thoroughly review all information submitted to determine the exact nature of the appeal. The majority of requests for appeal require additional review by the claims administrator. The average review takes approximately 60 days to complete. Some cases may require additional time for review depending on individual circumstances. Some cases may also require review by the state's independent medical consultant.

If consideration of your appeal does not result in a satisfactory resolution, the appeals coordinator may schedule it for additional review by the Insurance Appeals Staff Review Committee. When this occurs, the member will have the option of attending the committee meeting, or the appeal can be reviewed based on the written record. The Staff Review Committee will hear the appeal and their recommendation will be reported to the Appeals Subcommittee. The subcommittee will respond to the appeals coordinator within two weeks to indicate whether they agree with the Staff Review Committee's recommendation or vote to review the appeal at a second meeting. If the subcommittee agrees with the recommendation of the Staff Review Committee, the decision will stand. Members will be notified in writing as to whether or not requests are approved or denied by the committee. For denial decisions, the notification letter will explain any additional appeal options.

Q&A

Q Is my child who is attending college out of the service area covered at the network level?

A Children attending college out of the service area are always covered for a medical emergency. If your child requires ongoing routine care, then you may enroll him/her in the Guest Services Program This program links together network providers from Cigna networks across the United States. Please refer to the Guest Services section of this handbook for specific information.

Q How does the plan work for those who live outside of Tennessee?

A This plan is only available to you if you live and/or work in the service area.

Q Do I have a choice of hospitals?

A We have contracted with certain hospitals to provide care to you. If specialty care is not available at the contracted hospital(s), arrangements will be made to the appropriate non-network hospital.

Q What happens if my doctor disagrees with a medical policy regarding my covered treatment alternatives?

A A provider appeals process is available for this situation.

Q How are the lists of prescriptions requiring prior approval and prescriptions with quantity limitations determined and how can they be changed?

A These lists are developed and maintained by a committee. The lists are established annually and reviewed quarterly and contain medications that are clinically effective as well as cost effective. A member or provider may suggest changes to these lists by contacting our office. Suggestions will receive a written response.

Q What if my physician is out of the office?

A Physicians "cover" for each other on a rotating schedule. This means there may be times when you will not be able to speak with your physician. The nurse or physician on call will be able to help you.

Q What if I must reach my physician after regular office hours?

A Most physician offices utilize an answering service; therefore, when you call after regular office hours, you will most likely talk to a representative from the answering service. The on-call health care professional will request some identifying information and will need a general description of your urgent medical need.

HealthQuotient™ Health Risk Assessment

Get Informed, Then Get Control

You're ready to make a commitment to better health. But first, you need to better understand your personal health situation. Are there specific factors that contribute to your health? Are they hereditary? Are they controllable? Is there a healthy living plan out there that meets your unique needs?

If you're asking these questions, then you're ready to take WebMD's HealthQuotient™ Health Risk Assessment – a personal health management tool available to you on myCIGNA.com. And through the assessment, you'll learn what you need to get better control of your health and well-being.

Using a brief online questionnaire, HealthQuotient can help you:

- Identify and monitor your personal health status;
- Find out how social, environmental and family history may affect your health and well-being;
- Learn more about preventive care; and
- Be better prepared to have a discussion with your doctor.

The HealthQuotient Health Risk Assessment is just one of many tools CIGNA HealthCare offers on myCIGNA.com to help you make the most of the time you spend planning, managing and understanding your health benefits.

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